# State of Delaware: Highmark Comprehensive PPO



**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual + Family | **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.highmarkbcbsde.com** ***or*** by calling **1-800-633-2563**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$0**; Out-of- Network: **$300** person/**$600** family. Doesn't apply to preventive care, copayments or prescription drugs. Balance billing and excluded services do not count toward the **deductible**. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. In-Network Medical: **$4,500** person/**$9,000** family; In-Network Prescription Drug: **$2,100** person/**$4,200** family. Out-of-Network Medical: **$7,500** person/**$15,000** family; Out-of-Network Prescription Drug: No out-of-pocket limit. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance billing, health care this plan does not cover, bariatric surgery expenses and infertility expenses. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network **providers**, see **www.highmarkbcbsde.com, call 1-800-633-2563**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |

**Questions:** Call **1-800-633-2563** or visit us at **www.highmarkbcbsde.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-800-633-2563** to request a copy.

| | | |
|---|---|---|
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay | 20% coinsurance | -- None -- |
| | Specialist visit | $25 copay | 20% coinsurance | -- None -- |
| | Other practitioner office visit | 15% coinsurance for chiropractic care | 20% coinsurance for chiropractic care | Coverage is limited to 30 visits per plan year for chiropractic care. |
| | Preventive care/screening/immunization | No charge | 20% coinsurance | Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to **www.highmarkbcbsde.com** or call **1-800-633-2563** for specific information. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab: $5 copay; Machine Testing: No Charge | 20% coinsurance | -- None -- |
| | Imaging (CT/PET scans, MRIs) | $15 copay | 20% coinsurance | Prior authorization required. Failure to pre-authorize will result in a denial. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com. | Generic drugs | $8.50 copay for 30-day supply retail or mail order; $17 copay for 90-day supply participating retail or mail order | Reimbursement limited to in-network allowable amount minus applicable copay | Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when generic equivalent is available. |
| | Preferred brand drugs | $20 copay for 30-day supply retail or mail order; $40 copay for 90-day supply participating retail or mail order | Reimbursement limited to in-network allowable amount minus applicable copay | |
| | Non-preferred brand drugs | $45 copay for 30-day supply retail or mail order; $90 copay for 90-day supply participating retail or mail order | Reimbursement limited to in-network allowable amount minus applicable copay | |
| | Specialty drugs | Copay based on whether drug is generic, preferred, or non-preferred | Not covered | First fill can be at retail; future fills must be through specialty pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 20% coinsurance | -- None -- |
| | Physician/surgeon fees | No charge | 20% coinsurance | -- None -- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $150 copay (waived if admitted) | $150 copay (waived if admitted) | Care must be rendered within 48 hours of onset of symptoms. |
| | Emergency medical transportation | No charge | No charge | -- None -- |
| | Urgent care | $25 copay per day | 20% coinsurance | -- None -- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100 copay per day with $200 maximum per admission | 20% coinsurance | Pre-authorization required. Failure to preauthorize will result in a denial. |
| | Physician/surgeon fee | No charge | 20% coinsurance | Pre-authorization required. Failure to preauthorize will result in a denial. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $15 copay | 20% coinsurance | -- None -- |
| | Mental/Behavioral health inpatient services | $100 copay per day with $200 maximum per admission | 20% coinsurance | Pre-authorization required. Failure to preauthorize will result in a denial. |
| | Substance use disorder outpatient services | $15 copay | 20% coinsurance | -- None -- |
| | Substance use disorder inpatient services | $100 copay per day with $200 maximum per admission | 20% coinsurance | Pre-authorization required. Failure to preauthorize will result in a denial. |
| **If you are pregnant** | Prenatal and postnatal care | $25 copay for initial visit; no charge for subsequent visits | 20% coinsurance | -- None -- |
| | Delivery and all inpatient services | $100 copay per day with $200 maximum per admission | 20% coinsurance | -- None -- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No charge | 20% coinsurance | Coverage is limited to 240 visits per plan year. Pre-authorization required. Failure to pre-authorize will result in a denial. |
| | Rehabilitation services | 15% coinsurance; No charge for applied behavioral analysis (ABA) | 20% coinsurance | ABA limited to $36,000 per person per plan year to age 21. |
| | Habilitation services | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Skilled nursing care | No charge | 20% coinsurance | Coverage is limited to 120 days per benefit period. Benefits renew after 180 days without care. Pre-authorization required. Failure to pre-authorize will result in a denial. |
| | Durable medical equipment | No charge | 20% coinsurance | -- None -- |
| | Hospice service | No charge | 20% coinsurance | Coverage is limited to 365 days. |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Glasses | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Dental check-up | No charge under Delta Dental or Dominion Dental | 20% coinsurance under Delta Dental; not covered under Dominion Dental | Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Eye exam
- Glasses
- Habilitation services
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (up to age 24)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-633-2563. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Highmark Blue Cross Blue Shield Delaware at 1-800-633-2563 or www.highmarkbcbsde.com. Additionally, a consumer assistance program can help you file an appeal. Contact The Delaware Department of Insurance/Consumer Assistance Program, 841 Silver Lake Blvd., Dover, DE 19904 or 302-674-7300 (local), 1-800-282-8611 (toll free) or consumer@state.de.us.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-633-2563.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-633-2563.

CHINESE (**中文**): **如果需要中文的帮助**，请拨打这个号码 1-800-633-2563.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-633-2563.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,160
- **Patient pays** $380

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $230 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$380** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,830
- **Patient pays** $570

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $530 |
| Coinsurance | $0 |
| Limits or exclusions | $40 |
| **Total** | **$570** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.